STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155152	A. BUILDING 01 B. WING	01/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTICELLO ASSISTED LIVING AND HEALTHCARE	1120 N MAIN ST MONTICELLO, IN47960

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K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 01/04/12 Facility Number: 000072 Provider Number: 155152 AIM Number: 100287440 Surveyor: Bridget Brown, Life Safety Code Specialist At this Life Safety Code survey, Monticello Assisted Living and Healthcare was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This fully sprinklered facility consisted of a one story building	K0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567L Plan of Correction be considered the Letter of Credible Allegation and requests a Desk Review in lieu of a Post Certification Review on or after February 3, 2012.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	of Type V (000) construction with a partial basement and a two story building determined to be Type V (111). The facility was surveyed as two buildings due to different construction types. The facility has a fire alarm system with smoke detection in the basement, corridors and spaces open to the corridors. The facility has a capacity for 147 residents and had a census of 94 at the time of this survey. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 01/06/12. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by:			
K0044 SS=E	Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5 Based on observation and interview, the facility failed to ensure 1 of 7 fire door sets was arranged to automatically close	K0044	**K 044** It is the practice of this provider to ensure that each fire door set is	02/03/2012

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	and latch. LSC 7.2.4.3.8 requires fire barrier doors to be self closing or automatic closing in accordance with 7.2.1.8. NFPA 80, the Standard for fire Doors and Fire Windows at 2-4.1.4 requires all closing mechanisms shall be adjusted to overcome the resistance of the latch mechanism so positive latching is achieved on each door operation. This deficient practice affects visitors, staff and 41 residents on the 1 West and 2 West halls. Findings include: Based on observation with the maintenance director on 01/04/12 between 12:45 p.m. and 4:15 p.m., the 1 West and 2 West fire door sets were tested twice manually and again upon activation of the fire alarm. One door in the fire door sets failed to latch each time the doors were released to close. The maintenance director acknowledged at the times of observation, the doors did not latch and said they did when the latch mechanisms were adjusted.		arranged to close and latch each time they are released to close. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The 1 West and 2 West fire door sets have been adjusted and both sets close and latch each time they are released to close. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. All fire set doors have been released to ensure that they close and latch.	

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	3.1-19(b)		**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** A weekly test on fire doors has been added to the preventative maintenance weekly log. The Maintenance Supervisor or his designee is responsible. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The preventative maintenance log book will be reviewed during the monthly CQI meeting by the Interdisciplinary team. **Compliance Date: February 3, 2012**	
K0046 SS=E	Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. Based on observation and	K0046	**K 046** It is the practice of this	02/03/2012

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	interview, the facility failed to ensure 2 of 25 battery powered emergency lighting fixtures would operate. LSC 7.9.2.5 requires battery operated emergency lights shall be capable of repeated automatic operation. This deficient practice affects visitors, staff and 32 residents on 1 North and 2 North. Findings include: Based on observation with the maintenance director on 01/04/12 between 12:45 p.m. and 4:25 p.m., the battery powered emergency lighting in the 1 North exit corridor and the 2 North lounge failed to illuminate when tested twice. The maintenance director said at the times of observation, these lights were working when last tested and he thought they might need new batteries. 3.1-19 (b)		provider to ensure that each battery operated emergency lighting fixture operates as required. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The 1 North and 2 North emergency lighting fixtures have been tested and the batteries have been replaced. Both fixtures are working properly. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. All battery operated emergency lighting fixtures have been tested to ensure they are working properly. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** A monthly test of 30 seconds and an annual test of 90 minutes will be conducted on all emergency lighting fixtures. Batteries will be changed routinely and no less than once a year. The Maintenance Supervisor or his designee will be responsible. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance**	

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			program will be put into place? The preventative maintenance log book will be reviewed during the monthly CQI meeting by the Interdisciplinary team. **Compliance Date: February 3, 2012**	
K0050 SS=F	Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 Based on record review and interview, the facility failed to conduct required fire drills during 3 of the past 4 quarters. This deficient practice affects all occupants. Findings include: Based on a review of fire drill records for the past year with the maintenance director on 01/04/12 at 1:05 p.m., fire drill records were not found for the night shift during the first and fourth quarters or the first shift during the second quarter of 2011. The maintenance director confirmed at the time of record review, the fire	K0050	**K 050** It is the practice of this provider to ensure that fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** A fire drill was performed on third shift. Fire drills are performed 1 per shift per quarter utilizing each 2-hour time slot throughout each shift annually. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. Fire drills will be held at unexpected	02/03/2012

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	drills had not been done and noted there were two drills on other shifts for these quarters. 3.1-19(b) 3.1-51(c)		times under varying conditions, at least quarterly on each shift. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The Maintenance Supervisor or his designee is responsible to ensure that the fire drill schedule is followed.The fire drill schedule includes a fire drill each quarter, each shift. The fire drill log book will be reviewed during the monthly CQI meeting by the Interdisciplinary team. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The fire drill log book will be reviewed during the monthly CQI meeting by the Interdisciplinary team. **Compliance Date: February 3, 2012**	